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THE CONTENT OF INSTRUCTION IN CLINICAL PSYCHIATRY

by

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One of the most succinct descriptions of the historical development of psychiatry has been provided in the World Health Organization Expert Committee on Undergraduates teaching of psychiatry and mental health promotion (1961):

"There were psychiatrists of course, even before psychiatry was recognized as a branch of medicine worthy of being taught in Medical Schools. These early psychiatrists were mostly general clinicians who took a special interest in the diseases of the mind and most of them worked in asylums for the insane, apart from the rest of their medical colleagues. It was only around the middle of the last century that medical schools began to accept psychiatry as a subject to be taught in the curriculum, although only as an appendix to general clinical medicine and usually with a certain neurological emphasis.

"Later, psychiatry began to develop into a medical speciality. This was due to a general solidification of its scientific basis, to a great wealth of clinical experience, and finally to considerable improvement in its possibilities for therapeutic and preventative action.

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"Advances in the understanding of the function of the central nervous system, derived from the work of Neuro-anatomists, Neuro-physiologists and Neuropathologists, all played their part in consolidating the scientific basis of psychiatry. In this connection, special importance has to be attributed to the development of cortical syndromes such as the aphasias, apraxias and agnosias, and later on to the investigation of extra-pyramidial functions and of the finer anatomy and physiology of the vegetative system, particularly at the cerebral level. It is hardly necessary to point out that the Neuro-physiological approach is still adopted in modern research, for instance, in the field of epilepsy, cybernetics and brain chemistry".

The aspects of clinical psychiatry which merit discussion are many and varied. For pragmatic reasons it isnecessary to confine discussion to a few of the many aspects. These include the role of psychiatry in clinical medicine, its value in the education of medical students and its value in the promotion of mental health in the community. From a review of these the concept of the actual content of instruction will emerge as a logical sequence.

ROLE OF PSYCHIATRY IN CLINICAL MEDICINE

The first point to be considered is the increased demand for psychiatric care in the present day world. The most important reason for this, is of course, the fact that the population of the world has increased tremendously. There are more people living today that have ever been born. This alone would indicate the tremendous need for the treatment of any disease condition which may afflict human beings. The next important reason is that although in many less developed countries

there are urgent problems which face physical and preventive medicine in the fields of nutrition, maternal and child health and the prevention of infectious diseases. In all of these fields the actual toll of life has been and remains considerable; it is only very recently that consideration has been given to effects of psychiatric ill health on the community's well being and on its economic efficiency. In the more advanced countries this question can be viewed in a very different light where most of the problems mentioned above have either been overcome or reduced at least to a considerable extent so that psychiatric illness along with degenerative disorders has assumed the pre-eminent position. It is said that approximately 10% of a population in any one year are likely to be handicapped by sort of psychiatric symptoms either mild or severe. Next comes the vexed question of the alleged increase in the incidence mental disorder, and its supposed connection with the artificial life of civilized society.

In the early days, the bulk of information about psychiatric disease was collected from the data relating to the inmates of the asylums for the insane. The development of psychiatry as a medical speciality in the 19th century was also related to the building of these institutions which performed a custodial function for the more severely disturbed members of the community. The figures were kept mostly for administrative purposes. The investigators who dealt with them were the Medical Officers making use of the records of their own institutions. In England, the Registrar General's Office had a Public Health Officer, William Farr, who published a pamphlet on the statistics of English Lunatic Asylums as early as 1838 (1). Prichard (2) in 1835 also emphasized the different admission rates from urban and agricultural areas and Stark (3) in the 1850's, showed that the insane were drawn more often from the lower than from the middle and upper classes. Workers in the United States claimed a higher incidence of mental

illness in the old settled areas than in the new pioneer states (4); other workers compared the figures in different years wondering whether there was an increase in the incidence of mental illness. Maudsley (5) studied the apparent increase in England between 1840 and 1870 concluding that it did not correspond to any real trend.

Even to the present day the controversy has not been unequivocally decided. Most studies that have been done recently are based on General Practices and they point to a high incidence of emotionally determined illness in the population although figures vary considerably. But Hopkins (6) gives 11.1% for "Formal Psychiatric Illness", an additional 31.7% for less clearly definable stress disorders, making a total of 42.8% of all patients seen by him. Shepherd (7) in a recent carefully conducted study based on several Practices in the London area arrived at the conclusion that the incidence of emotional illness in a population of nearly 15,000 at this time amounts to 140 per 1,000 or 14%. The majority of consultations were for Psychoneuroses (88.5 per 1,000) and "Psychiatric associated conditions" (48.6 per 1,000), a category used to include psychosomatic conditions (29.9 per 1,000), organic illness with psychiatric overlay (15.0 per 1,000), psychosocial problems (7.5 per 1,000). Shepherd also points out that patients' emotionally determined illnesses make greater and more frequent demands on their General Practitioners than the rest of their practice population. About 1 adult in 7 consulted his or her doctor at least once during the survey year with symptoms, wholly or in part of emotional origin. American findings give higher figures of 20% (8); there can therefore be no doubt that emotionally determined illnesses of all kinds constitute a large proportion of the work of general and of the medical profession as a whole.

Inspite of the undoubted importance of emotionally determined illness in all branches of medicine the training of doctors in the psychosocial aspects of medicine is gravely neglected. Both the British College of General Practitioners and the report of the Royal Commission on Medical Education have focused attention on the need to prepare doctors for the large amount of emotional illness they have to deal with. This training is, of course, specially important for the General Practitioners who are the first to come into contact with patients needing help with emotional problems. But hospital specialists are equally involved, although some of them may be less aware of the fact than others that those sent them for specialist opinion may have symptoms which require psychological understanding as well as physical investigations.

If we turn now to the actual content of teaching and its relationship to mental health and its promotion we find we must admit that the purpose of a medical school is to train doctors who have a broad perspective of the whole field of medicine and to allow those who have a special interest and the talent to go into a specialist field. It is essential therefore, that psychiatry which is of such profound importance both to the general practitioner and of course, to the specialist himself should be presented by stimulating teachers who have the status and the prestige which equals that of their colleagues who are teaching other physical diseases.

It cannot be denied that the two basic disciplines from which one can enter Psychiatry are Neurology and the Behavioural Sciences. This should be taught in a dynamic rather than in a static fashion with a routine description of their stark and uninteresting anatomical structures and their fibre connections.

The importance of teaching Behavioural Sciences cannot be minimized because not only are they important to the learning of psychiatry but they are also essential to enable general practitioners from dealing with a

even many specialists who fail to regard the patient as a person rather than the carrier of a certain disease. The Behavioural Sciences include Psychology, Sociology, Social Administration and Ecology.

The importance of Neurology to the study of Psychiatry cannot be over emphasized. It is a truism to say that psychiatric illnesses have their seat in the brain and therefore it becomes inevitable that there should be many conditions which form the borderline between neurology and psychiatry. It is essential to know both and to be familiar with each. The present day miracle of psychopharmacology is really rooted in neurochemistry and neuropharmacology.

DIAGNOSTIC CATEGORIES

Medical Students should see as many and varied examples of every diagnostic category which include major psychoses, mental retardation psychoneuroses, adult and child behaviour problems and addictions. It is essential that the undergraduate should be able to see the cases over an extended period of time, if necessary spread across intervals and also must be able to participate in the treatment of minor psychiatric disorders through the simple but very rewarding process of simple goal directed psychotherapy under supervision. This apart from being the best way of teaching dynamics gives the medical student a sense of participation in a way which he cannot get anywhere else.

Anxiety states which constitute a large proportion of the problems which the medical student will have to face when he goes into practice are very good examples to which he can be exposed under supervision physical conditions associated with anxieties like tension headaches, eneuresis and sexual maladjustments.

Exposure to the work of the almoner or the Psychiatric Social Worker is also likely to be of profound interest and great benefit to the medical student.

THE DYNAMIC APPROACH

The young medical student should know that mental disorders are the result of many forces from within the patient as well as his environment; the importance of genetics must be emphasized to him as well as the constitutional factors which are of profound importance. These dynamic interplay of factors provide the basis of the Psychodynamic approach. The fundamental contribution of this approach has been to draw attention to the psychological forces for the understanding of normal and abnormal human behaviour and all psychiatric illnesses. This has been of great importance in view of the tendency to over emphasize the purely biological and environmental aspects of mental illness; the word 'dynamic psychiatry' implies the continuous interaction of psychological and physical phenomena, and the influence of personality development in childhood as well as of social relationships on present day patterns of living and reacting. In the latter case, this concerns itself with the study of intrapsychic phenomenon including conscious and unconscious mental processes along with the inter-personel phenomena specially the doctor-patient relationship.

INTERVIEWING

The classic method of taking a medical history is from patients who suffer from a well-defined physical illness. Here he can be asked direct questions for which the patient is expected to give direct answers; the purpose being to get a clear description of physical symptoms to decide whether or not it fits into the picture of an organic illness. If the doctor's attention is oriented towards diagnosing physical disease, he is likely to ignore any statement made by the patient which leads him away from this purpose; consequently, the patient is discouraged from talking about certain topics even though they may be of importance to him. In this process a large and important area of the patients' illness and their personal reaction to it is likely to be ignored. The social history has also to be similarly limited to a few questions concerned with housing,

The correct technique should be to teach medical students the very simple, yet, skilful art of interviewing; the essentials of which are:

1) To learn to listen rather than to ask questions.

2) To follow up the leads that the patients offer.

3) To open up areas of enquiry the patient does not mention on his own accord.

4) To use one's own emotional reaction to the patient's suffering and carefully controlled empathy to discover what sort of person he is, what he feels, and what he is going to do to others including his doctor.

5) Of special importance is a need to find out in detail what was happening to the patient at the time his symptoms commenced, how he reacted to his life circumstances at that time and what they meant to him.

Such methods are, of course, used by many doctors with a natural gift; in fact professional interviewers can give very good examples of highly skilled interviews

METHODS OF INVESTIGATION

The most important investigations is a carefully obtained history but the medical student must also be exposed to a few of the investigations which are carried out as a routine in the better institutions. These include the physical tests like the Electro-Encephalogram, a good formal neurological examination, the simpler psychological tests like Raven's matrix and T.A.T.

It is also essential to teach the medical students the awareness of danger signals which include severe depression and consequent risk of suicide.

CLASSIFICATIONS

It is essential that the medical student who is trained to think in

terms of disease entities as separate water-tight compartments because of his training and experience in other branches of medicine should be given a simple, understandable and logical method of classification of psychiatric illnesses. Against the background of the basic information that psychiatric conditions are usually not as water-tight as those in other specialities from each other, the classification offered to him should be simple enough for him to assimilate.

PROPOSED CLASSIFICATION

(1) Psychogenic Maladaptive Reactions

These include the so-called minor disorders or neuroses, in which symptoms arise largely as a result of emotional conflicts and frustrations. The patient himself is often unaware of the motive-force or the 'reasons' behind the symptoms. The symptoms, though at times very incapacitating and unpleasant, do not involve a distorted appreciation of reality - the moon is still perceived as the moon and the sun is still believed to rise in the east. Many of the symptoms, especially anxiety and depression, are merely exaggerated forms of normal biological reactions to stress.

(i) Affective-Dissociative reactions: These are characterized by various combinations of anxiety, depression and dissociation. Anxiety is felt as a fear of vague, incomprehensible dangers from within; in depression there is a feeling of gloom or 'down in the dumps', while in dissociation the patient shows an ability to detach himself from his symptoms.

(ii) Obsess -Compulsive reactions· There is repeated awareness of an idea or impulse along with a subjective sense of compulsion which is clearly recognized as senseless and consciously resisted, but the resistence is always overcome by compulsion.

The psychogenic disorders of childhood and those following trauma at any age (post-traumatic neurosis) can also be discussed under these headings.

(2) Mental Illness Primarily due to a Demonstrable Disease in the Body or Brain, or Disturbance of the Body Processes

This category includes the major disorders, psychoses or 'insanities' in which the whole of the personality is usually affected leading to distorted perception and interpretation of experiences.

The following are the main groups:

(i) Organic Psychoses: There is disturbed consciousness or awareness of the surroundings, incoherence or fragmentation of thoughts and actions, failure of grasp and memory and misinterpretation of experiences. Two main types of organic psychosis are recognized:

(a) Acute and Subacute Delirious States due to infections, fevers, poisons, nutritional deficiences and failure of the heart, kidneys, or liver. These are also called symptomatic psychoses. The cardinal feature is clouding of consciousness or reduced wakefulness.

(b) Dementias: Presenile, Senile and Cerebrovascular. There is an irreversible, often progressive, degeneration of the brain cells leading to deterioration of intellect, loss of memory and dilapidation of personality.

Injury and alcoholism are the only other important causes of Dementia.

(ii) Affective Psychoses: Two clinical types are recognized:

(a) Manic-Depressive Psychosis. There is a profound and sustained disturbance of mood which may be one of depression and retardation, or of elation and over-activity. There are respectively gloomy or grandiose misinterpretations of experiences. These occur in youth and middle age.

(b) Involutional Melancholia. It is a special form of depression with marked agitation and gloomy preoccupation with the body, occuring for the first time in the involutional period which ranges roughly from 40 to 55 years in women and from 50 to 65 years in men.

(iii) Schizophrenia. Literally meaning 'splitting', it is probably a group of many related conditions. There is usually a slow and insidious onset in youth, and attendency to progressive withdrawal of interest from the environment, blunting and inappropriateness of emotional responses (affect) and splitting or a sort of loosening of fabric in thought processes.

Affective psychoses and schizophrenia are often classed together as functional psychoses but this is not recommended as it gives the false impression that the function of the mind is disturbed without necessarily any primary disturbance in the body processes. The primary causes in these disorders probably lie in some biochemical derangements in the body which are genetically determined.

(III) Predominantly Genetic and Constitutional Disorders

(1) Mental Deficiency (Amnesia): characterized by below average intelligence.

(2) Psychopathy: a failur to develop normal emotional responsiveness and other temperamental qualities necessary for health socialization.

(3) Sexual Perversion: a failure to develop normal sexual aims and objects.

(IV) Alcoholism and Drug Addictions.

A person is said to suffer from alcoholism if he drinks in excess to the detriment of his health, or if he becomes increasingly dependent upon alcohol for his normal psychological and physiological functions so that when deprived of it he shows withdrawal symptoms.

The term drug addiction is used when dependence develops for a drug other than alcohol.

A CONSIDERATION OF TREATMENT

The aspect which is of greatest importance to patients and to practising doctors is the question of treatment. The method of treatment which is most closely associated with psychiatry, and the method in which psychiatry presents the most original record and the most important contribution is that of psychotherapy. The second mainstay of treatment, and this really represents some of the greatest advances of chemistry and pharmacology is the treatment with drugs and other forms of physical therapy. The third important method which is utilised in psychiatric treatment, although not as tangible and perhaps not as well understood is the environmental manipulation that is often required after the drug and physical treatment, and the establishment of a psychotherapeutic relationship, a degree of confidence and stability has been infused in the patient. It is in this area that the psychiatric social worker renders invaluable help.

The general aim of psychotherapy is to improve the patients capacity to deal with his own problems, to adjust himself to the conditions of his life and to make the best possible use of his own emotional and intellectual resources. Psychotherapy essentially is a form treatment by communication which covers all forms of exchange of ideas, of discussion, of reasoning, of the effort to reach out into the mind and world of sick person and by comprehending it to make it comprehensible to him, even enabling him to proceed in a different way and to modify his behaviour, along the lines governed by this new and wider understanding and by an increased confidence. This therefore, requires the confidence of the patient in the doctor and skilled understanding by the doctor of the patient's predicament. There are two broad categories into which psychotherapy can be divided. The first is the supportive kind and the second may be called the interpretive kind; it is the area of interpretive psychotherapy which is comprised of the various analytical approaches and within the analytical approaches many schools that have emerged out of the original contribution by Freud.

The supportive psychotherapy is usually simple, less ambitious in aim and easiest in execution, and therefore, more suitable for demonstration and practice to the medical student. It may include all the techniques of counselling direct, sensible and sympathetic advice, and other reassurance and encouragement. The supportive psychotherapy can play a great part in the out-patient management of patients who might otherwise receive no help whatever from their doctors.

Interpretive psychotherapy is based upon the number of principles which were established largely by the early study of the Freudian School of psycho-analysis into the elements of human emotional development and the unconscious

mental life. The first of these is that behaviour is prompted chiefly by emotional considerations, but understanding is necessary to modify and control such behaviour. The second is that a very significant proportion of human emotions, together with the action to which it leads is not accessible to personal introspection, since it is rooted in the areas of the mind which are below the surface of consciousness. The third principle which is derived from the first two is that any process which makes available to individual consciousness the true significance of these emotional conflicts and attentions which have been repressed will produce a heightened awareness and with it increased stabilit and emotional control. This in turn will lead not only to improved health but also to a more mature and developed personality.

The essential in the psychotherapeutic interview is an ample time for the patient to describe his difficulty without interruption from the doctor, and the doctor must be disposed to listen to them with unwavering patience and attention. This is a skill which is more easily acquired by example than by precept.

Also included in this group of psychotherapeutic techniques and employed as auxiliary method in any form of therapy are those methods which are designed to provide occupation to the patient in hospital or at home who are unable to carry on the normal work of their daily life. This type of activity is old occupational therapy and the secret lies in arousing the patient's interest and improving his morale by leading him to discover that there are useful things which are still done satisfactorily. It also provides contact and interest which although allied to the general purpose and direction of the medical treatment are separated from immediate supervision and administration of doctors and nurses, it is not simply a means of passing time but an active method of treatment with a profound psychological justification.

The use of drugs in the treatment of psychiatric disorders is too well-known to justify repetition here. Very briefly the two main groups of drugs which are used are tranquilizers and anti-depressants. There is a myriad variety of each of these, and new ones are being added every day with greater claims to efficacy and safety. What is essential for medical students to learn is the correct use of one or two of these drugs which he can master. It is imperative that he should be able to give the right dose for the right period of time before abandoning the drug or his diagnosis or both.

Electro-Convulsive Therapy despite its alarming name, is one of the safest proceduresin psychiatry, and indeed is the most effective form of treatment in depression. In its modified form the patient, who is on an empty stomach is given an intravenous injection of a short acting barbiturate and a short acting muscle relaxant which will paralyse the muscles for two to three minutes. As soon as a patient is asleep and relaxed which takes less than half a minute, a 90 volts current is passed through electrodes placed on the temples. If it succeeds in firing a fit which will show slight twitching in the hands, feet, and in the face. In the case of a failure a further shock of slightly longer duration is given. After the fit the patient is given oxygen until he starts breathing normally. The whole process takes about 10 minutes and the patient has no recollection of the shock or the fit. The medical student can see this treatment being given and also observe the dramatic results which follow four or six treatments in somebody who is completely and utterly depressed.

After the successful use of drugs physical method of treatment and psychotherapy comes that turn of social measure which seeks to alter the

patient's environment. These include recommendation about condition of work, provision of alternative employment, or housing, general advice to employers or the members of the family: all aimed at eliminating some of the social difficulties with which the patient has found himself unable to contend. These are the province of the trained psychiatric social worker acting under the general supervision of the doctor.

A medical student should see the various forms of treatment that have been described, and perhaps participate in some of them, and witness the team work which is necessary to achieve improvement in the patient, it emphasizes to him the importance of the various emotional,social and environmental factors in the development of psychiatric illness. It also emphasizes to him the need to seek and enlist the co-operation of a number of agencies that are arraigned in support of the patient that have been described, and perhaps participate in some of them and witness the team work which is necessary to achieve improvement in the patient, it emphasizes to him the importance of the various emotional social and environmental factors in the development of psychiatric illness. It also emphasizes to him the need to seek and enlist the co-operation of a number of agencies that are arraigned in support of the patient.

In conclusion, it may be said that: "The contribution of psychiatry to a fuller understanding of the principles and the practices of medicine was to underline a single fundamental truth; the ultimate wholeness and essential dignity of man. (10)".

REFERENCES

1. Farr, W. (1838). On the statistics of the English Lunatic Asylums, London.

2. Prichard (1835). A Treatise on Insanity and other disorders affecting the mind (LONDON).

3. Stark, J. (1851). J. Stat., Soc., (London), 14, 48.

4. White, W.A., (1903). J. Nerv., ment., Dis., 30, 257

5. Maudsley, H. (1872). Brit. Med. J., i., 36

6. Hopkins, P. (1956). Brit. Med. J., ii, 873

7. Shepherd, M. et al (1966). Psych. Illness in gen., practice Oxford Univ. Press., London.

8. Leighton, D.C., et al. Amer J. Psychiat., 119, 1021

9. Singh, M.M., (1967). Mental Disorder, Pan Books London

10. Stafford Clark, D. (1960). J. of Roy. Soc., of Arts.